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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					16176				
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> c. LENGTH OF STAY IN 1b <u>1 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Station Hospital, USNAS, Patuxent River</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> d. STREET ADDRESS <u>38 W. Rennell</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Arthur Wayne ADAMS</u>					4. DATE OF DEATH <u>November 10 1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 APR 1946</u>		9. AGE (In years last birthday) <u>20 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jet Engine mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Earl Adams</u>					14. MOTHER'S MAIDEN NAME <u>Martha Marie Ramsey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>					16. SOCIAL SECURITY NO. <u>376 48 3814</u>				
17. INFORMANT <u>Personnel office, USNAS, PAXRIVMD</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries</u> Multiple Extreme 866X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Aircraft accident</u>				
20c. TIME OF INJURY Month, Day, Year <u>3:30 p.m. NOV 10 1966</u>					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Runway, USNAS</u>					20f. (City or town) <u>Patuxent River</u> (County) <u>St. Mary's</u> (State) <u>Maryland</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>J. I. Smith</u> EXAMINER'S NAME (Type) <u>J. I. Smith</u>					22. DATE SIGNED <u>10 NOV 66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>USNAS, PAXRIVMD</u>				
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Nov. 15, 1966</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>					23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Virginia</u>				
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley, Leonardtown, Maryland</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
DATE <u>NOV 16 1966</u>									

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Wm. D. Davis
and family

Wm. D. Davis
and family

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16178

CERTIFICATE OF DEATH

16177

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DAMERON		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MYRTLE Middle EVELYN Last ALLEN				4. DATE OF DEATH Month NOVEMBER Day 2 Year 1966				
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1922		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ALVIN ALLEN				14. MOTHER'S MAIDEN NAME LUCY YOUNG				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-16-3339		17. INFORMANT MRS SHIRLEY BENNETT Address DAMERON Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoïd 1380 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 1 , 19 63 , to Nov 2 , 19 66 that (I) (we) last saw the deceased alive on Nov. 2 , 19 66 and that death occurred at 12:34 M, from causes and on the date stated above.								
22a. SIGNATURE W.H. Patrick				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/3/1966		
22c. PHYSICIAN'S NAME (Type) W.H. PATRICK M.D.				22d. ADDRESS CALIFORNIA. MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		NOV 5, 1966		ST PETER'S CLAVERS CEM.		RIDGE ST. MARY'S Md		
24. FUNERAL DIRECTOR JOHN M. WELCH				ADDRESS LEONARDTOWN MARYLAND		25a. REC'D BY REGISTRAR NOV 7 1966		
				25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16179

CERTIFICATE OF DEATH

16178

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lexington Park</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>18-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Snowden</u> Middle <u>Sylvester</u> Last <u>Chase</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cloored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Chase</u>		14. MOTHER'S MAIDEN NAME <u>Annie Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Theresa Thomas Lexington Park, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> DUE TO (b) <u>Laemoren Carbonic Fire</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 1966</u> to <u>Nov 1966</u> , that (I) (we) last saw the deceased alive on <u>8 September 1966</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest Rehn M.D.</u>		22b. DATE SIGNED <u>28 Nov '66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest Rehn M.D.</u>		22d. ADDRESS <u>Lexington Park, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 28, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Great Mills, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. REGISTRAR'S SIGNATURE		DATE <u>NOV 29 1966</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16180

CERTIFICATE OF DEATH

16179

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN TB <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		18.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Spencer</u> Last <u>Cusic</u>		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George P. Cusic</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Ann Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-244231</u>	
17. INFORMANT <u>Mrs Daisy A. Cusic</u>		Address <u>Leonardtown, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture Aortic Aneurysm (abdominal)</u> 451X DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10+ yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>John F. Fenwick</u>		22b. DATE SIGNED <u>11-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John F. Fenwick M. D.</u>		22d. ADDRESS <u>Leonardtown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Leonardtown, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 14 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16181

CERTIFICATE OF DEATH

16180

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABEEL, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ALMORE DICKERSON				4. DATE OF DEATH Month Day Year NOVEMBER 20 19 66			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 5, 1885		9. AGE (In years last birthday) yrs. 81	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OYSTERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE D.C. DICKERSON				14. MOTHER'S MAIDEN NAME MARY VIRGINIA BRANSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-9128		17. INFORMANT ELIZABETH B. DICKERSON		Address ABEEL, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Failure Hypertensive Crisis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/26 , 19 54 to 1/20 , 19 66 that (I) (we) last saw the deceased alive on 1/20 19 66 and that death occurred at 9A M, from causes and on the date stated above.							
22a. SIGNATURE Charles Greenwell				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL, M.D.				22d. ADDRESS LEONARDTOWN, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 23, 1966		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City or Town) (County) (State) BUSHWOOD ST. MARY'S Md.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				25a. REC'D BY REGISTRAR NOV 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16182

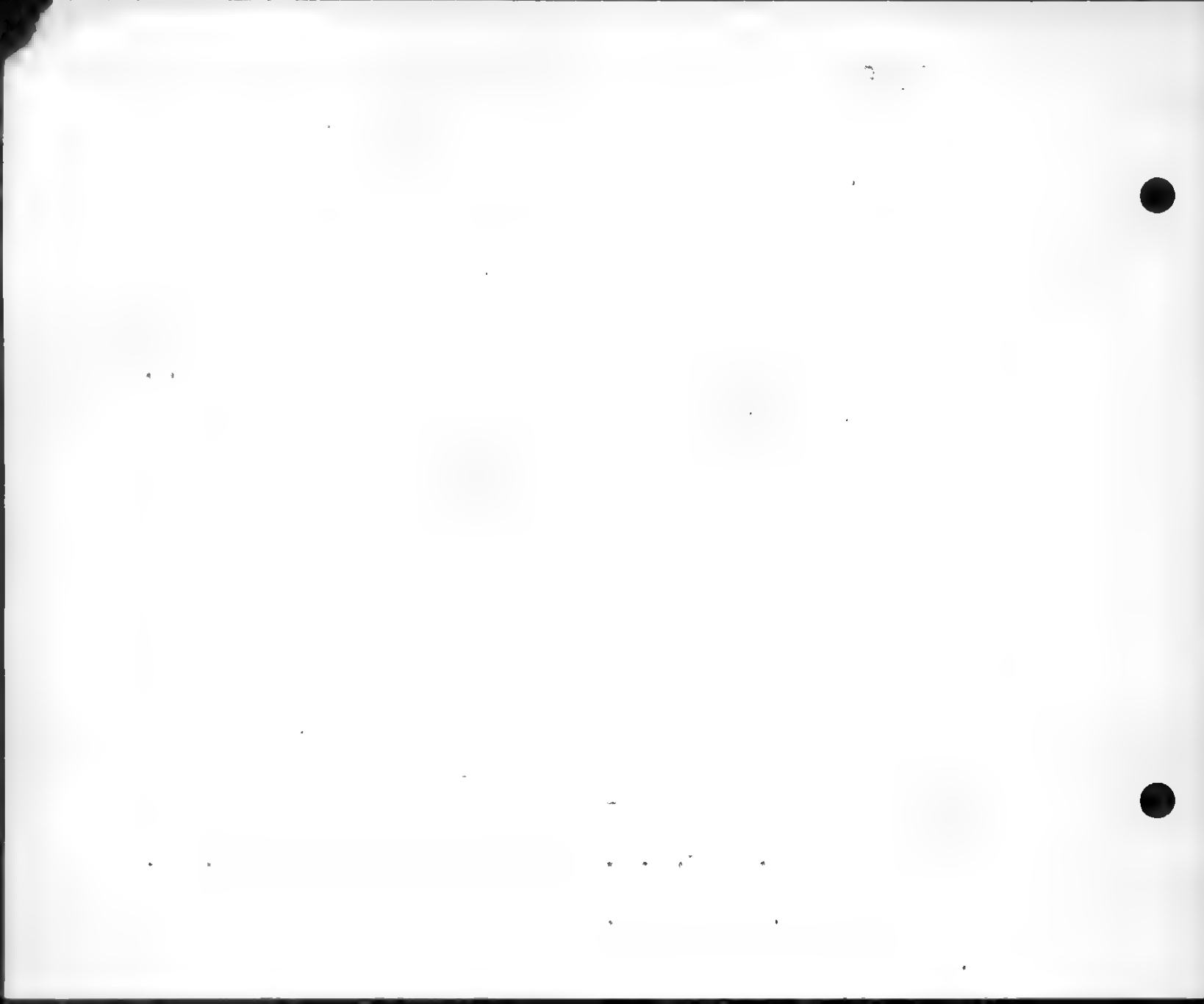
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16181

1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		c. LENGTH OF STAY in 1b 5 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mechanicsville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Andrew Middle James Last Douglas		4 DATE OF DEATH Month Nov Day #7 Year 1966	
5 SEX male	6 COLOR OR RACE colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 8, 1949
9 AGE (In years, lost birthday, yrs) 17		10 IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min 17	
10a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b KIND OF BUSINESS OR INDUSTRY Farming	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John Jasper Douglas		14 MOTHER'S MAIDEN NAME Agnes Marie Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-54-5652	
17 INFORMANT Father		Address same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FIBRINO-PURULENT PERITONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LACERATION OF COLON DUE TO (c) no			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) passenger in automobile involved in accident.	
20c. TIME OF INJURY Month, Day, Year 7:00 PM 11 6 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) street	20f. (City or town) (County) (State) Route 302, 1 1/2 miles west of Mechanicsville, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED Nov. 8th. 1966	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Nov. 8th. 1966	
23a. BURIAL OR CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 10, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery	23d. LOCATION (City or Town) (County) (State) Morganza, Maryland
24 FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland		25a. REC'D BY REGISTRAR NOV 14 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ⁹⁴ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

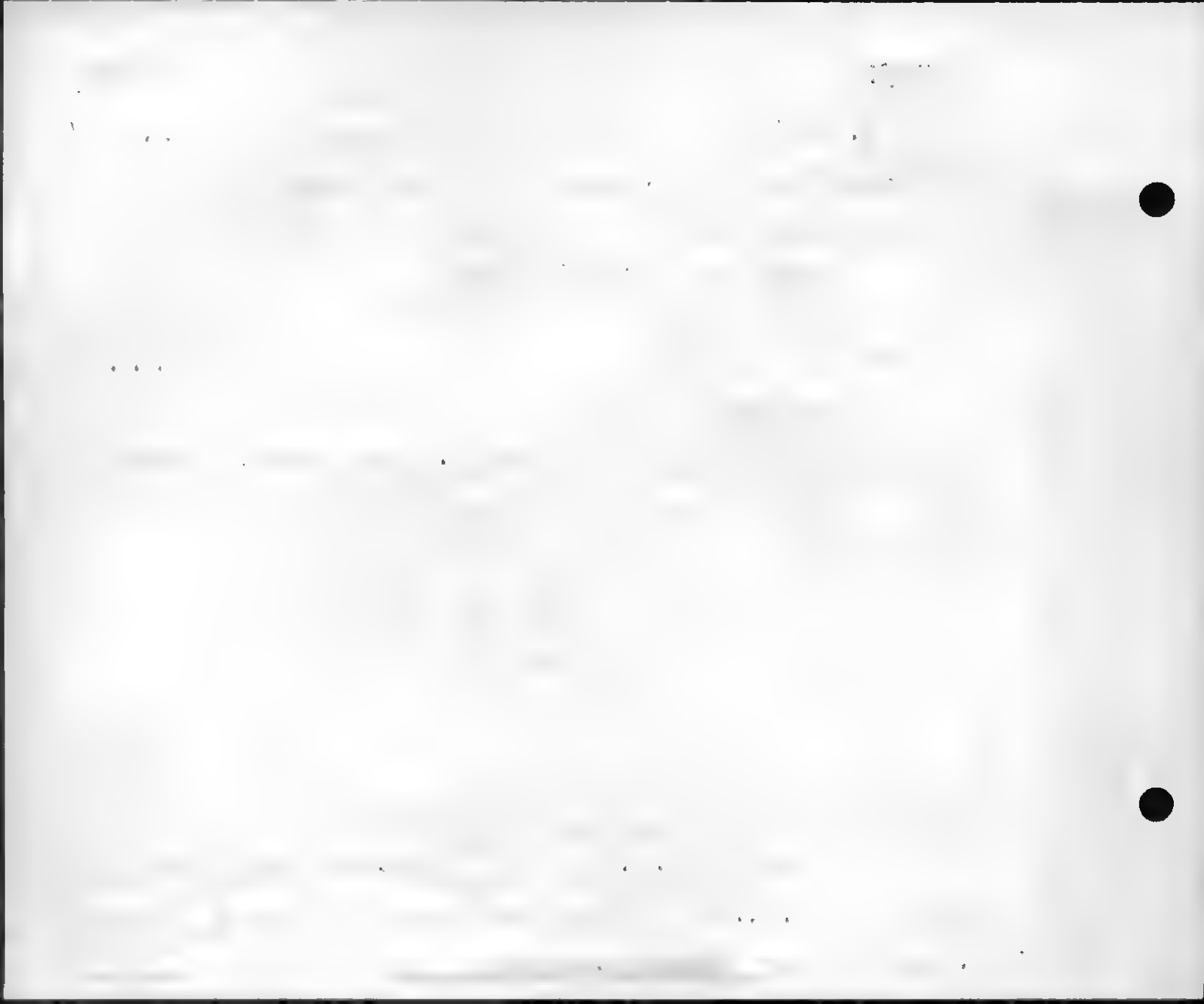
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16183

CERTIFICATE OF DEATH

16182

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Park Hall Rural</u>			c. LENGTH OF STAY IN 1b <u>3 years</u>			c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Rural Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Courtneys Nursing Home</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Richard</u> Last <u>Dyson</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1886</u>	9. AGE (in years last birthday) <u>80</u> yrs	10. IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min <u>00</u>		11. IF UNDER 24 HRS Hours <u>00</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Richard Dyson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Smother</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thomas H. Dyson</u> Address <u>Avenue, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Wys</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>66</u> , to <u>25 Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>24 Nov</u> , 19 <u>66</u> , and that death occurred at <u>25 Nov</u> , 19 <u>66</u> , M, from causes and on the date stated above.							
21c. SIGNATURE <u>Ernest Rehm M. D.</u>			21d. ADDRESS <u>Lexington Park, Maryland</u>		21e. DATE SIGNED <u>28 Nov 66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Ernest Rehm M. D.</u>			22d. ADDRESS <u>Lexington Park, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bushwood, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

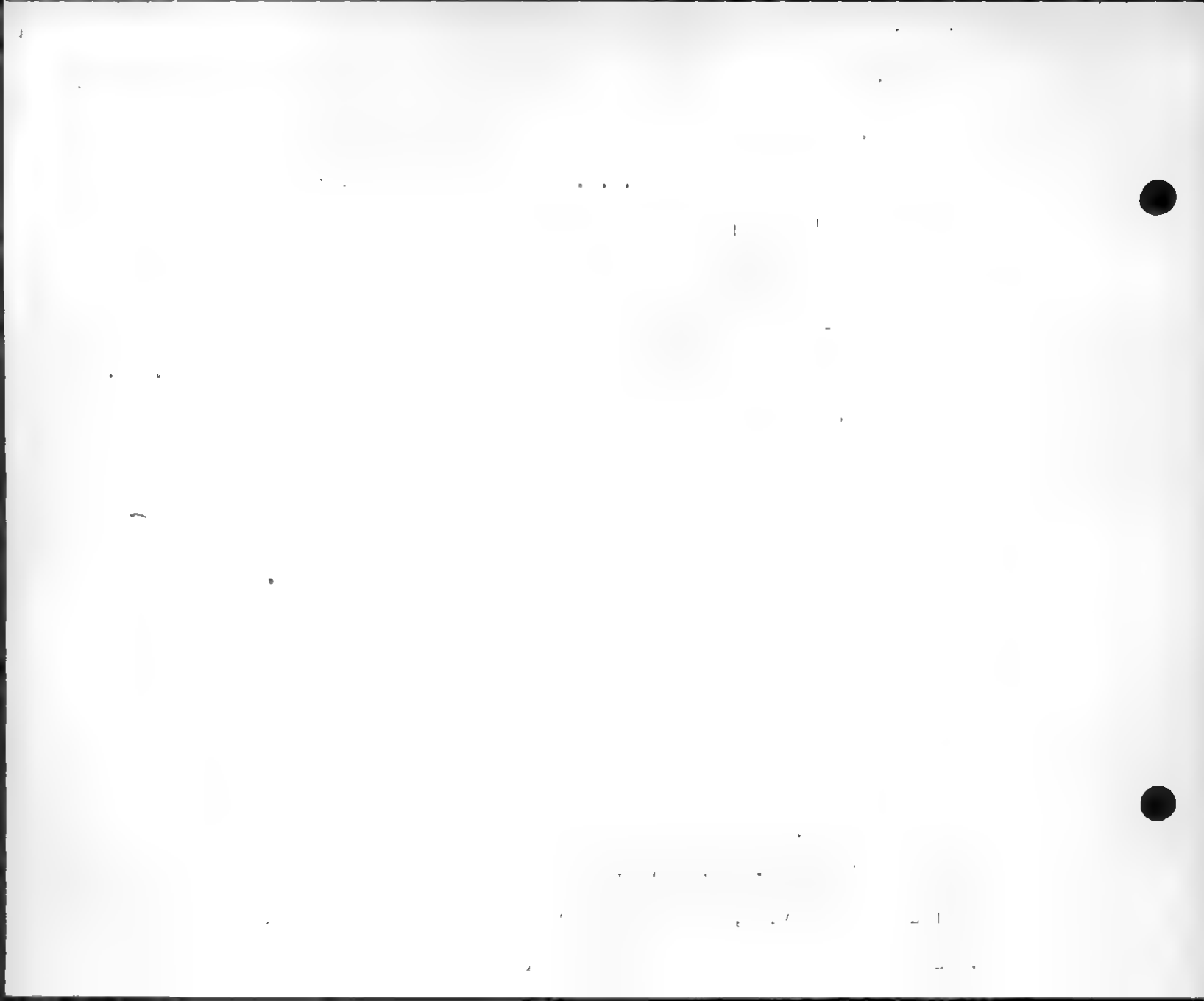
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16184

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16183

1 PLACE OF DEATH a COUNTY ST. MARY'S MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if not before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c LENGTH OF STAY IN 1b D.O.A.	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLEY		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL			d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last EDWARD FILLMORE JAMESON			4 DATE DEATH NOVEMBER 21, 1966		
5 SEX MALE	6 COLOR OR RACE COLORED	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 9, 1904	9 AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER OPERATOR		10b KIND OF BUSINESS OR INDUSTRY HOWARD UNIVERSITY		11 BIRTHPLACE (State or foreign country) ABELL, MARYLAND	
3 FATHER'S NAME PHILIP JAMESON			14 MOTHER'S MAIDEN NAME SADIE FILLMORE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW 11		16. SOCIAL SECURITY NO. 214-16-7826		17 INFORMANT THELMA B. JAMESON OAKLEY, MARYLAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO (b) Arterio Sclerotic HD Condition(s), if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William D. Boyd M.D. EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 11/22/66	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF Nov. 26, 1966	23c NAME OF CEMETERY OR CREMATORY ALL SAINTS CEMETERY	23d LOCATION (City or Town) OAKLEY,	(County)	(State) MARYLAND
24 FUNERAL DIRECTOR ADDRESS W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			25a REC'D BY REGISTRAR DATE NOV 28 1966	25b REGISTRAR'S SIGNATURE Charles J. [Signature]	



CERTIFICATE OF DEATH

Reg. Dist. No.

16185

16184

1. PLACE OF DEATH a. COUNTY <u>ST MARYS</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>ST MARYS HOSPITAL</u>				d. STREET ADDRESS <u>RT 1 BOX 190</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONARD JOSEPH KELLER</u>				4. DATE OF DEATH Month Day Year <u>NOV. 16, 1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 3, 1896</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOBACCO</u>		11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>LEONARD J. KELLER</u>				14. MOTHER'S MAIDEN NAME <u>REGINA SCHULER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-7053</u>		17. INFORMANT <u>GRACE KELLER, WALDORF, MD.</u> Address <u>RT 1 BOX 190</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - recurrent</u>						<u>20 hrs</u>	
DUE TO (b) <u>Atherosclerotic CV disease</u>						<u>6-7 yrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/16/66</u> , 19 <u>66</u> , to <u>NOV. 16</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>NOV. 16</u> , 19 <u>66</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11-16-66</u>							
ACTUAL SIGNATURE <u>J. Roy Guyther</u> M.D.				PHYSICIAN'S NAME (Type) <u>J. Roy Guyther M.D. MECHANICSVILLE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-18-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BRYANTOWN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 21 1966</u>		24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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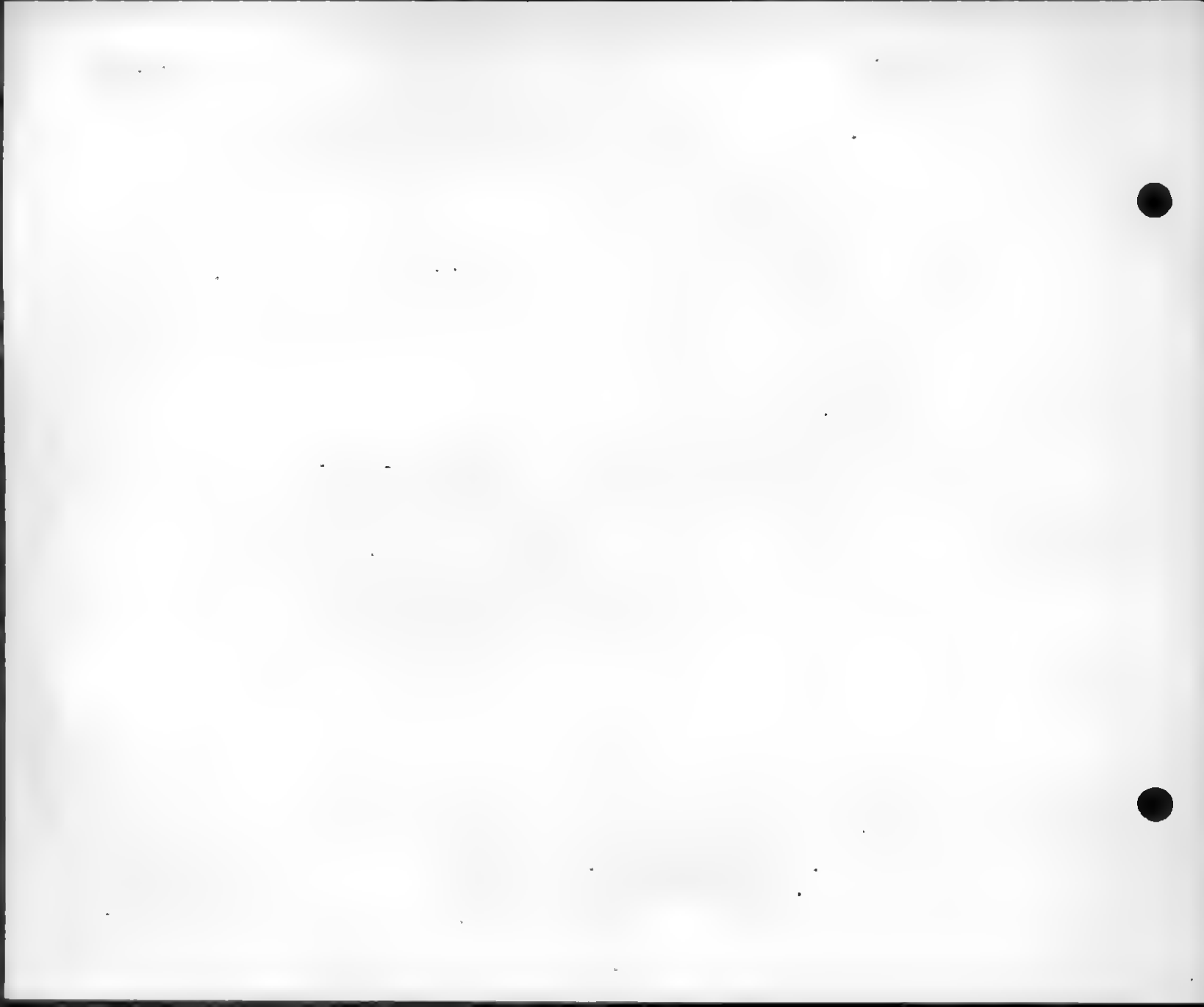
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16186 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16185

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Patuxent River c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL California d. STREET ADDRESS Box 105 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clifford Stanley LONCAR First Middle Last		4. DATE OF DEATH November 26 1966 Month Day Year	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1945 21 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK SUPPLY DEPT.		10b. KIND OF BUSINESS OR INDUSTRY US CIVIL SERVICE	
11. BIRTHPLACE (State or foreign country) YOUNGSTOWN, OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. Robert LONCAR		14. MOTHER'S MAIDEN NAME MAXINE R. SILLIMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 192 36 1541	
17. INFORMANT MRS. DAVID STRAUB - SAME AS # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries, Multiple DUE TO (b) Automobile Accident DUE TO (c) 25 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year 0130 a.m. 11/26 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route #235		20f. (City or town) (County) (State) Dameron St. Mary's Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Elliot L. Marcus		22. DATE SIGNED 26 NOV 66	
EXAMINER'S NAME (Type) Elliot L. Marcus LT MC USNR		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF 11/27/66	
23c. NAME OF CEMETERY OR CREMATORY MIDLAND - BEAVER CO. PA.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR John M. Welch - LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR NOV 29 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/1/1966	23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEM.	23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.		ADDRESS LEONARDTOWN, MD.	25a. REC'D BY REGISTRAR DATE DEC 5 1966
		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

VR A15 (4)
M 1/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

76

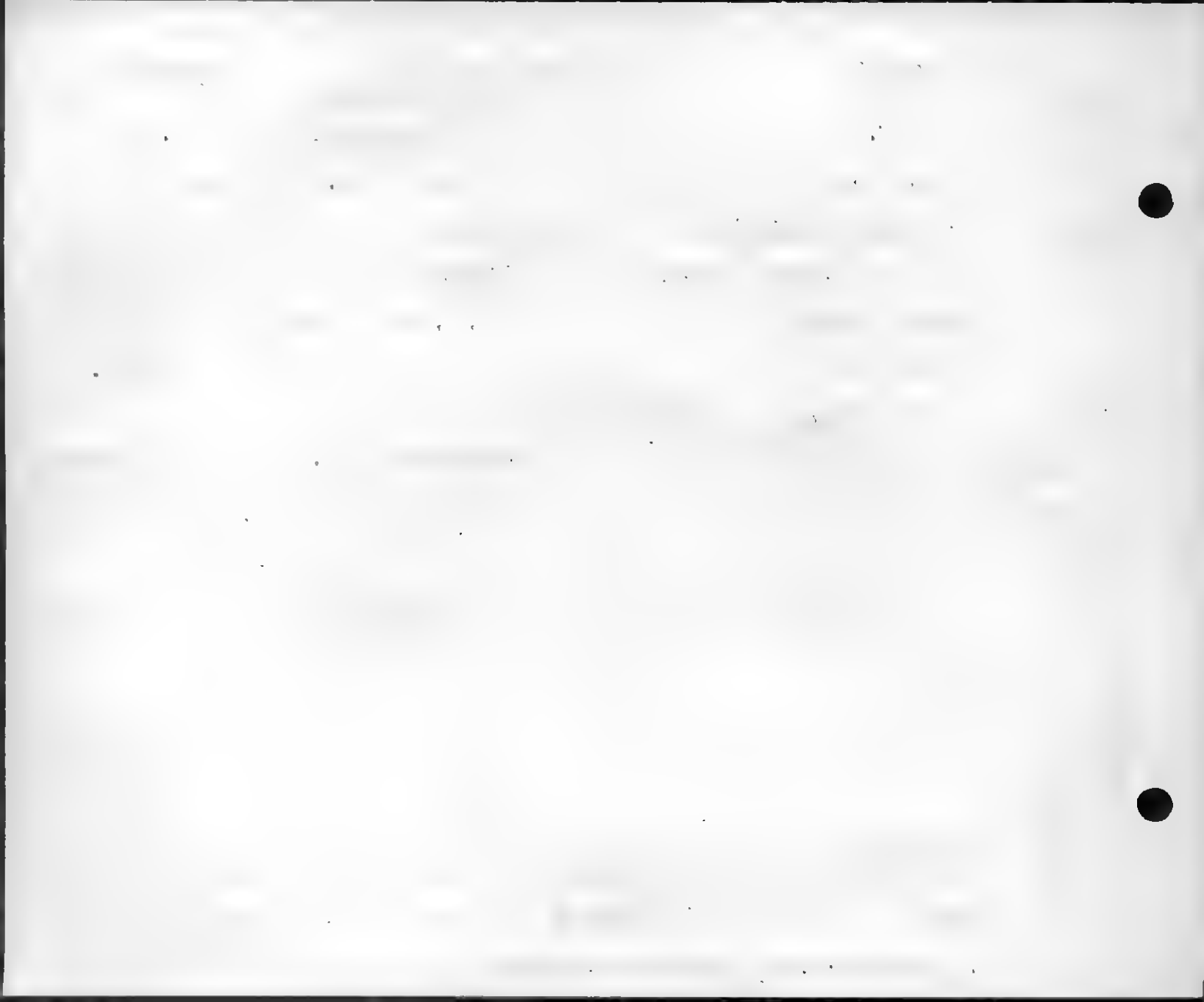
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16188

CERTIFICATE OF DEATH

16187

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>88 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				e. STREET ADDRESS <u>St. Mary's City</u>			
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>XXXXXX</u> Last <u>Milbarn</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1879</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isiah Holly</u>				14. MOTHER'S MAIDEN NAME <u>Sally Naylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Sol Milbarn</u> Address <u>St. Mary's City, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cachexia & Pleural Effusion</u> DUE TO (c) <u>Metastatic Carcinoma of Thyroid</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 11/20</u> , 19 <u>66</u> , to <u>11/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> , 19 <u>66</u> , and that death occurred at <u>1:40</u> M. from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>11/21/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. J. M. [Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11-23-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>House of God Church</u>	
23d. LOCATION (City or Town) (County) (State) <u>Park Hall Maryland</u>				23e. REC'D BY REGISTRAR <u>[Signature]</u>			
23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>				23g. DATE <u>28 1966</u>			
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>							



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16189

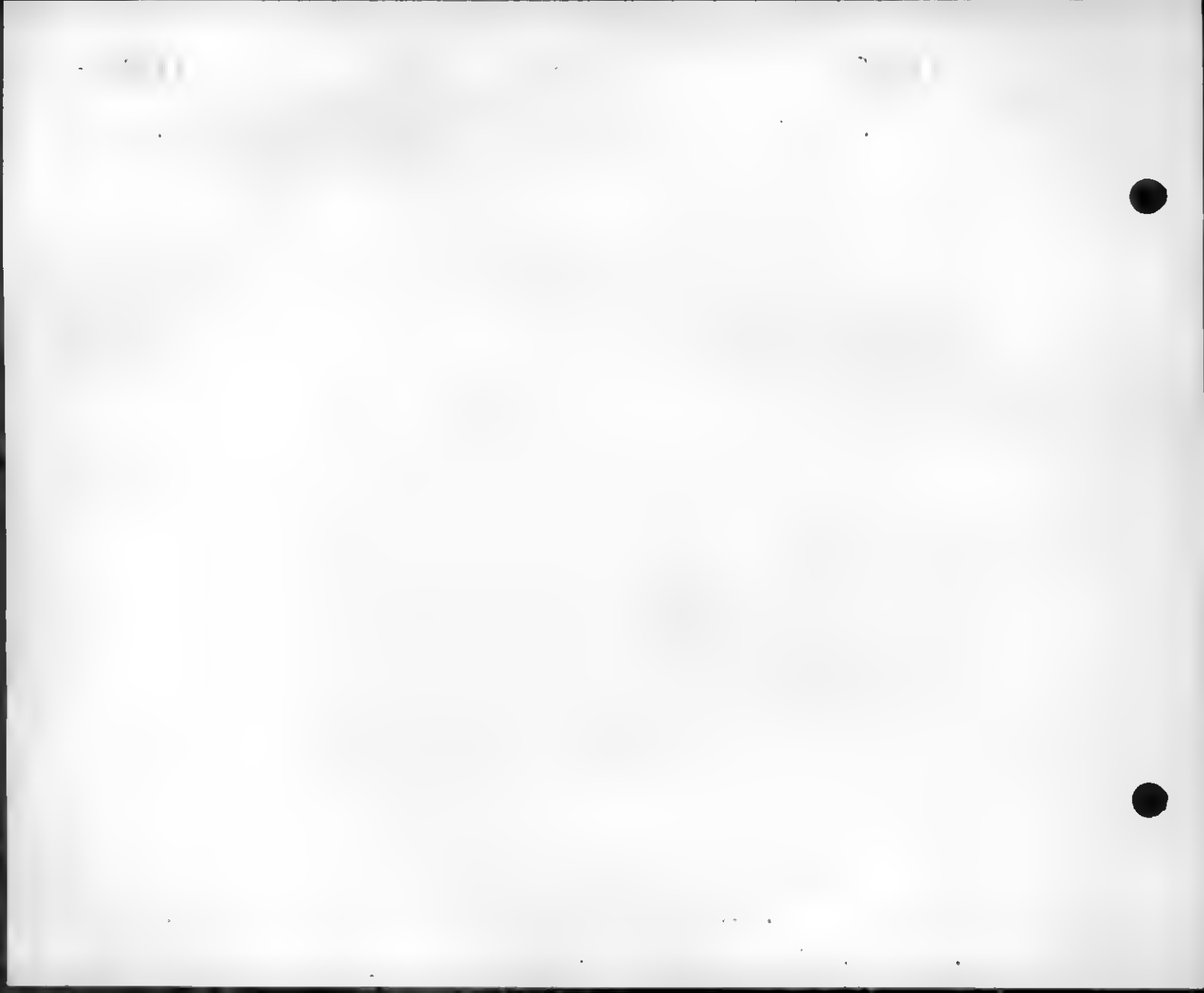
CERTIFICATE OF DEATH

16188

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River			c LENGTH OF STAY IN 15 Lexington Park		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital			d. STREET ADDRESS 12 Salamua Court		
3 NAME OF DECEASED (Type or print) Ida Mae MILES			4 DATE OF DEATH NOVEMBER 30 19 66		
5 SEX female	6 COLOR OR RACE Cau	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1912	9 AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Julian BRINKLEY			14. MOTHER'S MAIDEN NAME Blanche DUREY		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address Clair M. MILES Jr. same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DU Fulminating Septicemia DUE TO (c) Gram negative rod					INTERVAL BETWEEN ONSET AND DEATH 10 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE H.C. Robison			22b. DATE SIGNED 30 NOV 66		
22c PHYSICIAN'S NAME (Type) H.C. ROBISON LT MG USN			22d ADDRESS Same as #1		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 5, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland			25a. REC'D BY REGISTRAR Charles Judge		



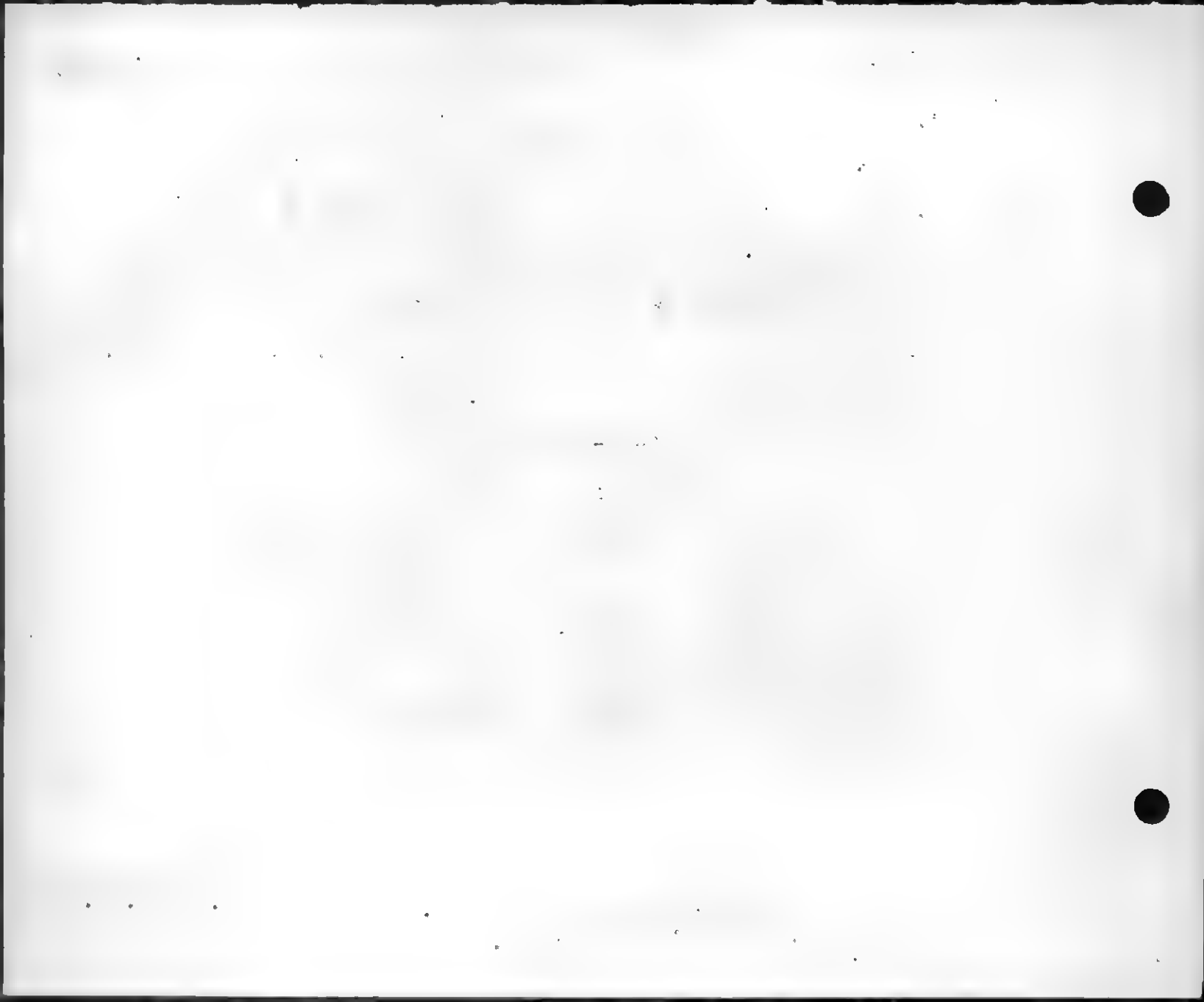
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16190 CERTIFICATE OF DEATH 16189											
1. PLACE OF DEATH a. COUNTY St. Mary's County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont						c. LENGTH OF STAY IN 1b XXXXX 3 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital						d. STREET ADDRESS XXXXXX XXXXX Route 2					
3. NAME OF DECEASED (Type or print) First Floyd Middle Victor Last Misner						4. DATE OF DEATH Month 11 Day 27 Year 66					
5. SEX male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-1892		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farm				11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Misner						14. MOTHER'S MAIDEN NAME Fannie Wolf					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-01-9295		17. INFORMANT John Misner Rt. 2. Thurmont, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral hemorrhage 1965										INTERVAL BETWEEN ONSET AND DEATH immediate 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 11:50 AM, from the causes and on the date stated above.											
22a. SIGNATURE P. J. BEAN MD						22b. DATE SIGNED Nov 27/66					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS Great Mills, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/30/1966		23c. NAME OF CEMETERY OR CREMATORY Creagerstown Cem.				23d. LOCATION (City, town or county) (State) Creagerstown, Fredk. Co. MD	
24. FUNERAL DIRECTOR Raymond E. Creager				25a. REC'D BY REGISTRAR DATE NOV 30 1966				25b. REGISTRAR'S SIGNATURE J. Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16191

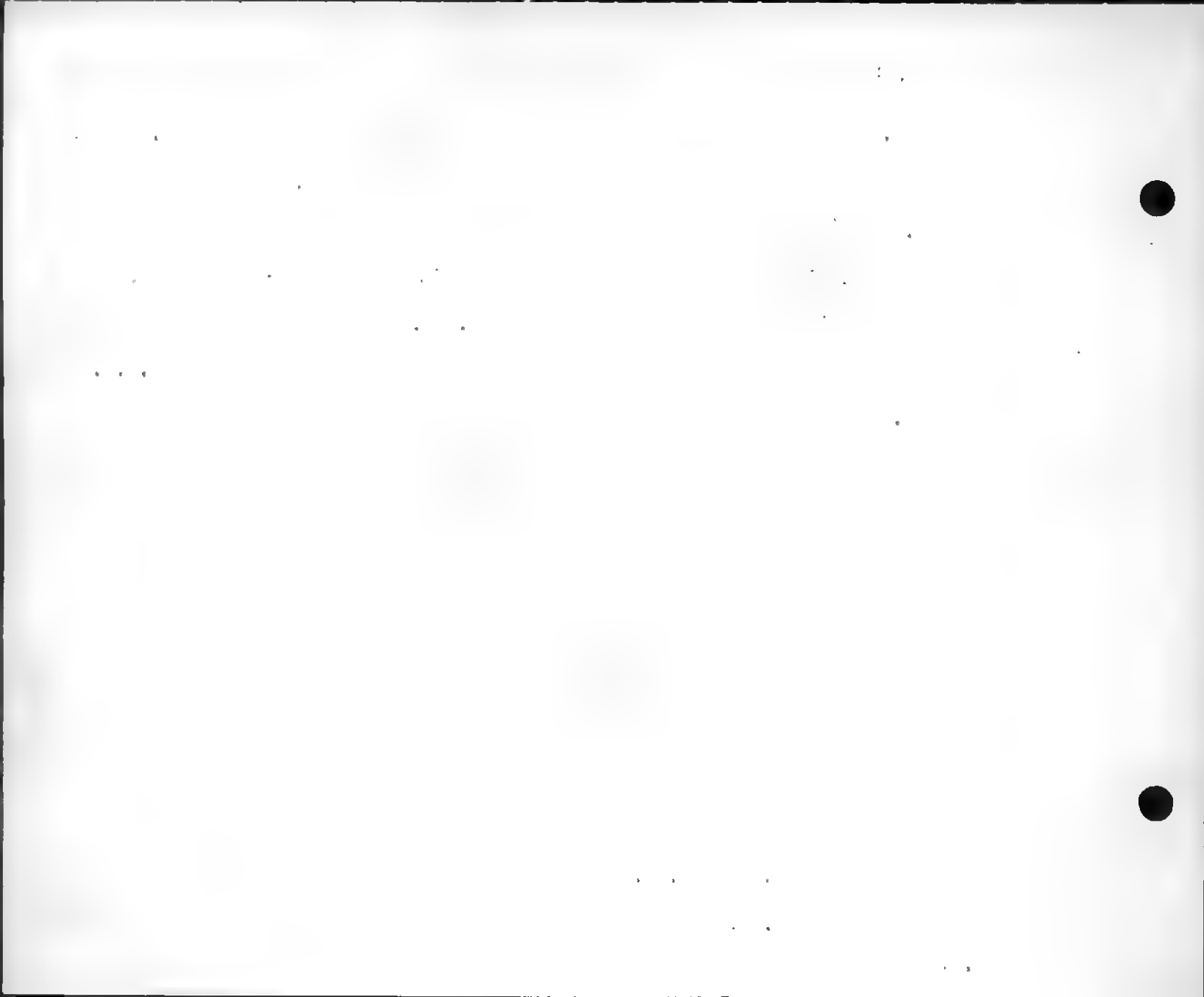
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16190

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN b. <u>26 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Reginald</u> Last <u>Norris</u>		4 DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 25, 1949</u>
9 AGE (in years last birthday) <u>17</u> yrs		10 IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min <u>17</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12 KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>J. Jennifer Norris</u>		14. MOTHER'S MAIDEN NAME <u>Almer Deloris Bean</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Father</u>		Address <u>same as # 2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun Shot</u> DUE TO <u>1190</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1190</u> DUE TO (c) <u>1190</u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot himself pulling gun out of car by the barrel</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:55 p.m. 11-13 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) <u>Great Mills</u> (County) <u>St. Mary's</u> (State) <u>MD</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William D. Boyd M.D.</u>		22. DATE SIGNED <u>11/16/66</u>	
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 17, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Great Mills Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

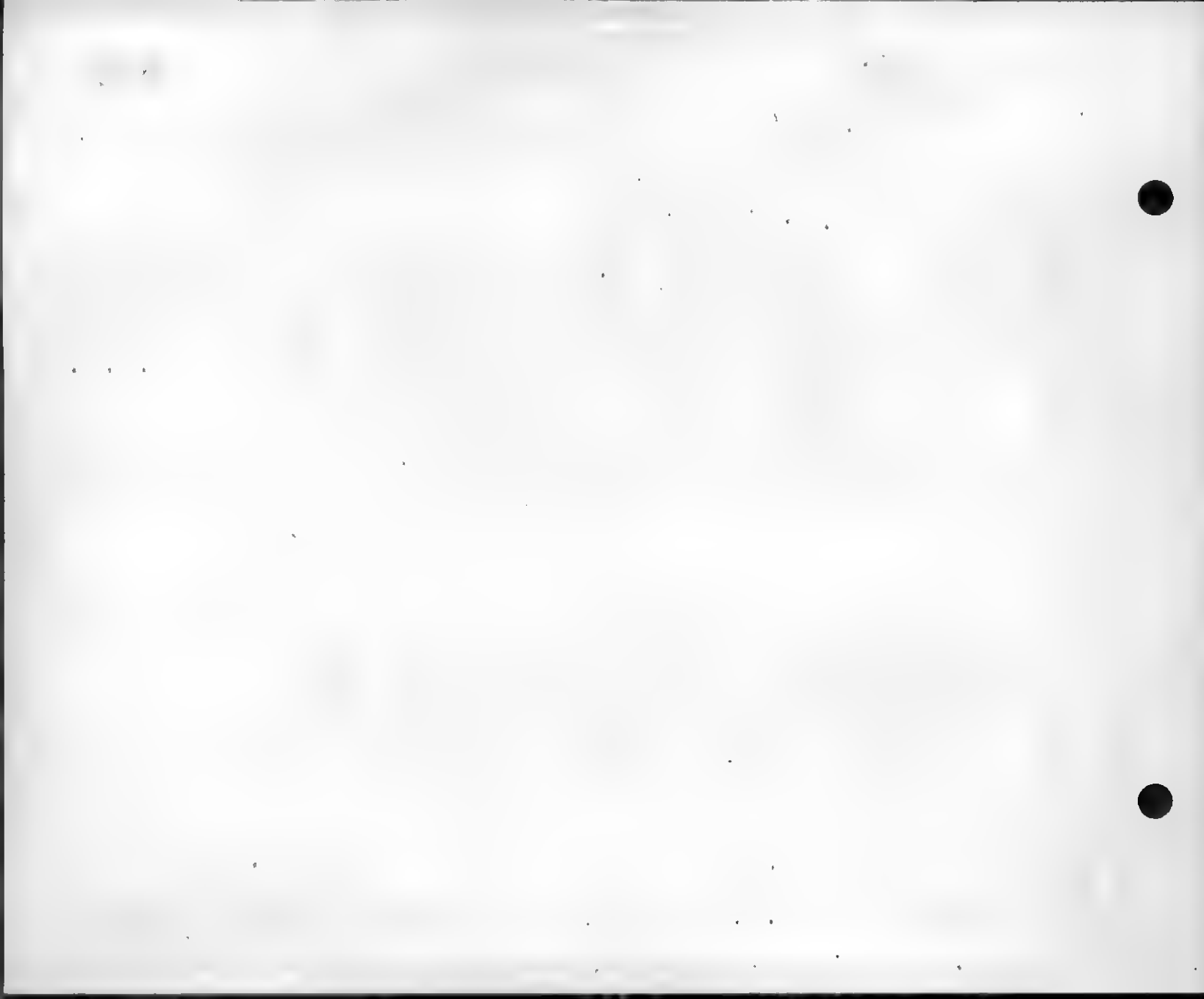
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16192

CERTIFICATE OF DEATH

16191

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN IS <i>18 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>D.</i> Last <i>Owen</i>		4. DATE OF DEATH Month <i>November</i> Day <i>22</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 3, 1882</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Tom Owen</i>	
14. MOTHER'S MAIDEN NAME <i>Belle Greene</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>228-28-2679</i>	
16. SOCIAL SECURITY NO. <i>228-28-2679</i>		17. INFORMANT <i>Mrs. Kate E. Owens, California, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i> DUE TO (b) <i>Coronary Occlusion</i> DUE TO (c) <i>Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>min.</i> <i>min.</i> <i>yes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4201</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <i>Jan. 11, 1966</i> to <i>11/22, 1966</i> , that (I) (we) last saw the deceased alive on <i>11/22, 1966</i> , and that death occurred at <i>9:54 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>James P. Jarboe M. D.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>James P. Jarboe M. D.</i>		22d. ADDRESS <i>Great Mills, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 25, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Joy Chapel Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hollywood, Maryland</i>	
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley, Leonardtown, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 28 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16193

CERTIFICATE OF DEATH

16192

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First EUGENE Middle MATTHEW Last PURCELL				4. DATE OF DEATH Month NOVEMBER Day 21 Year 1966			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1886	9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAT FINISHER			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) PINEY POINT, MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME THOMAS T. PURCELL				
14. MOTHER'S MAIDEN NAME ? ?			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 				
16. SOCIAL SECURITY NO 215-32-0466			17. INFORMANT MRS WILMER M. KERBE Address 1232 BREWSTER STREET				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 5271 IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO BALTIMORE 27, Mo. (b) Bronchopneumonia DUE TO (c) Emphysema						INTERVAL BETWEEN ONSET AND DEATH days yes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		
20f. (City or town) (County) (State) 			21. I certify that (I) (the hospital) attended the deceased from 11/21/66 to 11/22/66 , that (I) (we) lost saw the deceased alive on 11/21/66 , and that death occurred at 9 P.M. from causes and on the date stated above.				
22a. SIGNATURE J. Patrick Jarboe M. D.			22b. DATE SIGNED 11/22/66		22c. PHYSICIAN'S NAME (Type) J. Patrick Jarboe M. D.		
22d. ADDRESS Great Mills, Maryland			23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				
23b. DATE THEREOF Nov. 25, 1966			23c. NAME OF CEMETERY OR CREMATORY TRINITY EPISCOPAL		23d. LOCATION (City or Town) (County) (State) ST. MARY'S CITY, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY			25a. REC'D BY REGISTRAR NOV 28 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

FOR STATE HEALTH DEPT.

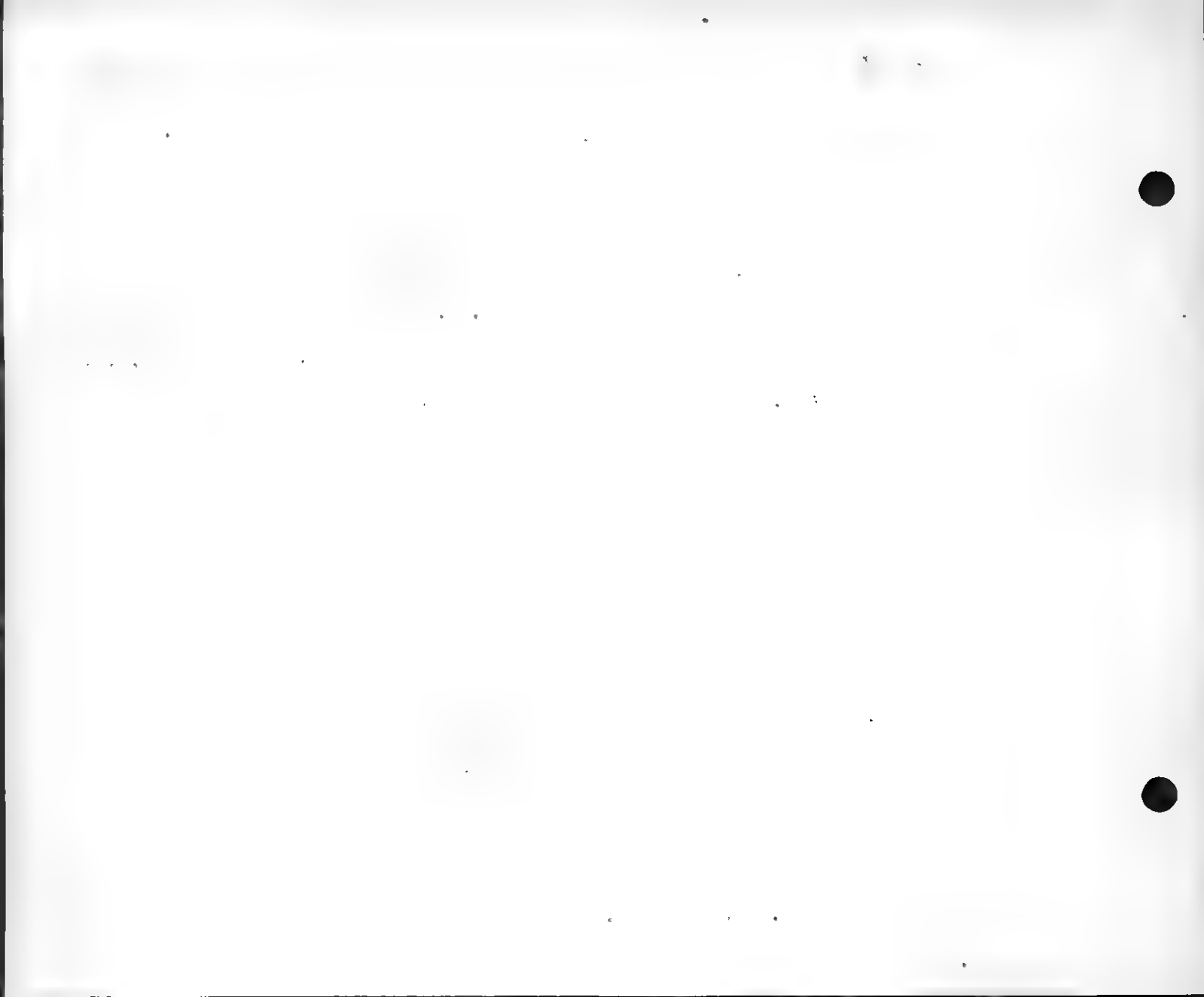
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16194

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16193

1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Compton 181		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				a. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last HORACE BERNARD ROBINSON				4 DATE OF DEATH Month Day Year November 13 1966			
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 23, 1946		9 AGE (In years last birthday) 20 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Horace Robinson				14 MOTHER'S MAIDEN NAME Mary Florine Turner			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17 INFORMANT Address Mother same as # 2 above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Gunshot wounds of Chest 7:10 A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Was shot in chest					
20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 11/12 1966		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State) Leonardtown Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breitenecker M.D. EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.				22. DATE SIGNED 11/13/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 17, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Francis Xavier		23d. LOCATION (City or town) (County) (State) Compton Maryland	
24 FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland				25a. REC'D BY REGISTRAR DATE NOV 16 1966		25b. REGISTRAR'S SIGNATURE f Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

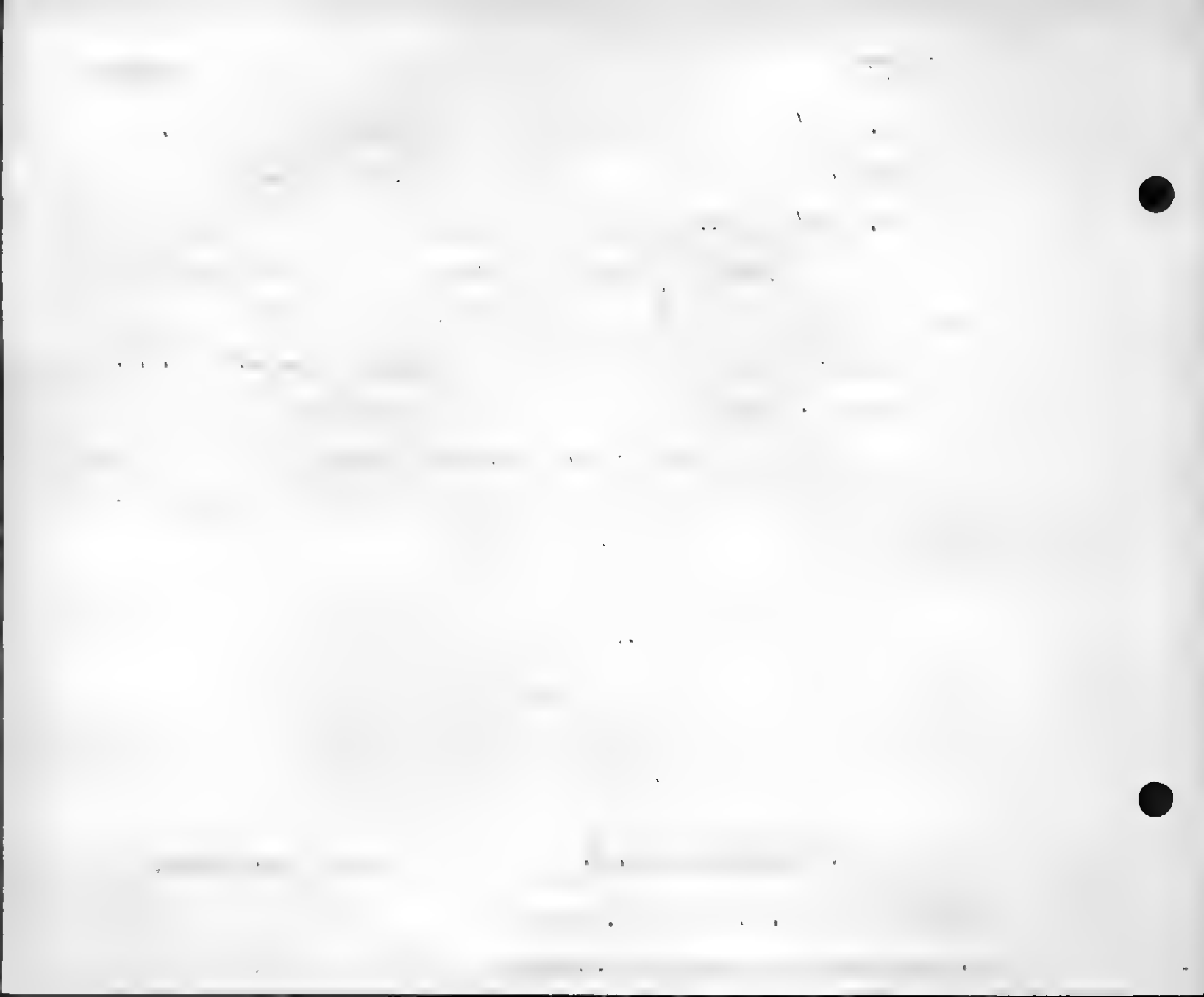
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16195

CERTIFICATE OF DEATH

16194

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>Rural Clements</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				d. STREET ADDRESS <u>161</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>James</u> Last <u>Russell</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1894</u>	9. AGE (in years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u> Hours <u>5</u> Min.		11. IF UNDER 24 HRS Hours <u>5</u> Min.
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming & Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Clements, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jackson P. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Farr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-34-2751</u>		17. INFORMANT <u>Mary Emily Russell</u> Address <u>Clements, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROBABLE CARCINOMA LUNG</u> 1163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHIECTASIS</u> DUE TO (c) <u>5 YRS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS, EMPHYSEMA</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>48</u> , to <u>Nov 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 17</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Foy Gaylor</u>				22b. DATE SIGNED <u>Nov 21 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>XXXXXX XXXXX XXXXX</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

FOR STATE
HEALTH DEPT.

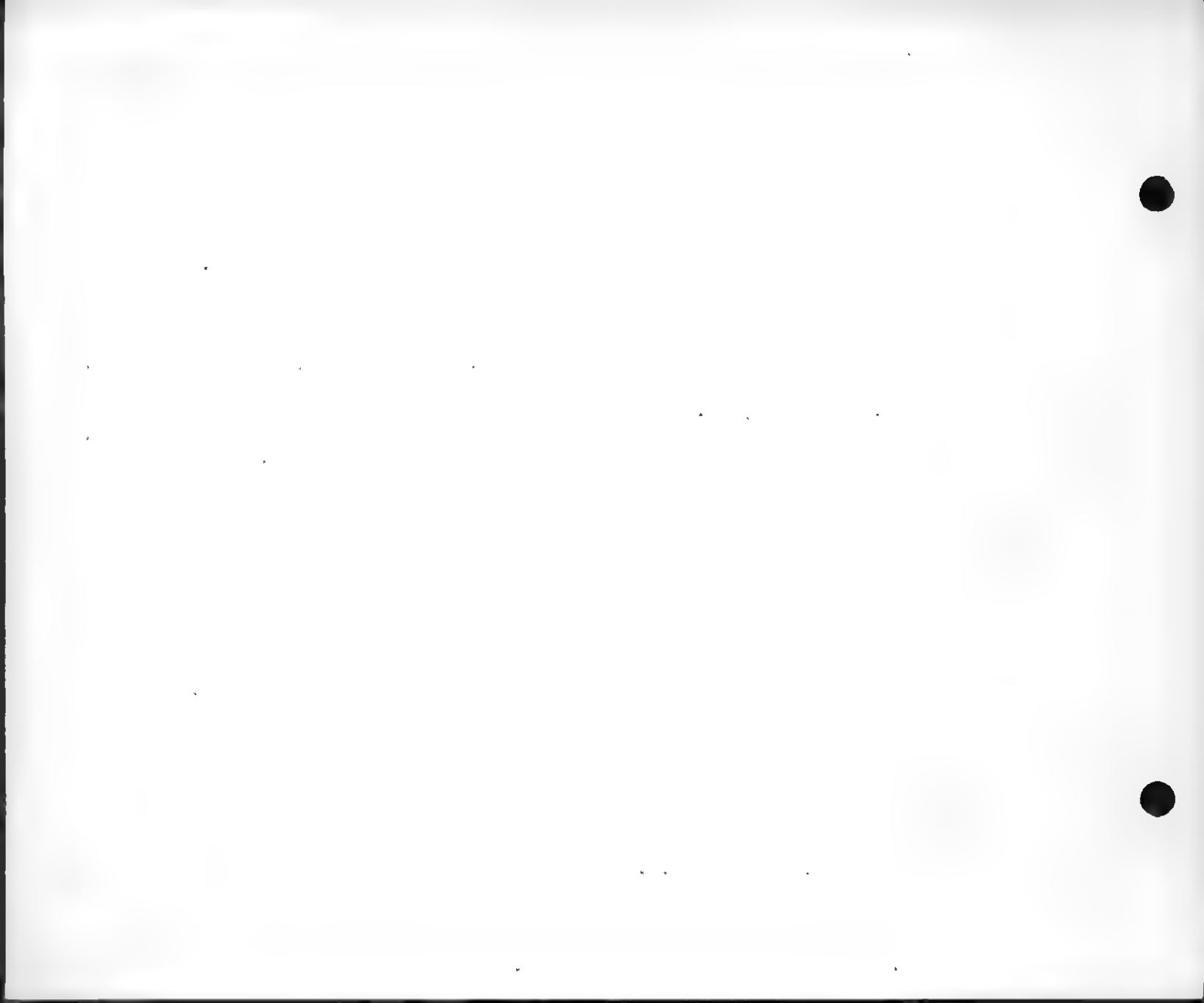
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16195

1 PLACE OF DEATH a COUNTY St. Mary's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY St. Mary's	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lexington Park		c LENGTH OF STAY IN 1b RURAL California	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d STREET ADDRESS Box 85, Route 2	
e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Lucinda First Hoodly Middle Schofield Last		4 DATE OF DEATH Month Nov. Day 18 Year 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6 - 10 - 1948
9 AGE (In years last birthday) 18 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months 18 Days 18 Hours 18 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b KIND OF BUSINESS OR INDUSTRY Furniture Sales	
11 BIRTHPLACE (State or foreign country) Greenwich, Conn.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Earle F. Schofield, Jr.		14 MOTHER'S MAIDEN NAME Millie Kaneruck	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 215 50 0155	
17 INFORMANT Earle F. Schofield, Jr. - California, Md.		Address Box 85 Rt. 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushing injuries of Head resulting from 5 ft DUE TO falling - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) INTERVAL BETWEEN ONSET AND DEATH INSTANT			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Auto accident Rt. 235 Lexington Park Maryland	
20c TIME OF INJURY Month, Day, Year Hour 9:45 am Nov 18 1966 pm		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Lexington Park		20f (City or town) (County) (State) St. Mary's	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. H. Patrick		22. DATE SIGNED 11-14-66	
EXAMINER'S NAME (Type) W. H. Patrick, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) TRANSIT	23b DATE THEREOF 11/20/66	23c NAME OF CEMETERY OR CREMATORY GREENWICH, CONNECTICUT	
23d LOCATION (City or town) (County) (State) Leonardtown, Md.		23e REC'D BY REGISTRAR DATE NOV 22 1966	
23f REGISTRAR'S SIGNATURE John M. Welch		23g REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16197

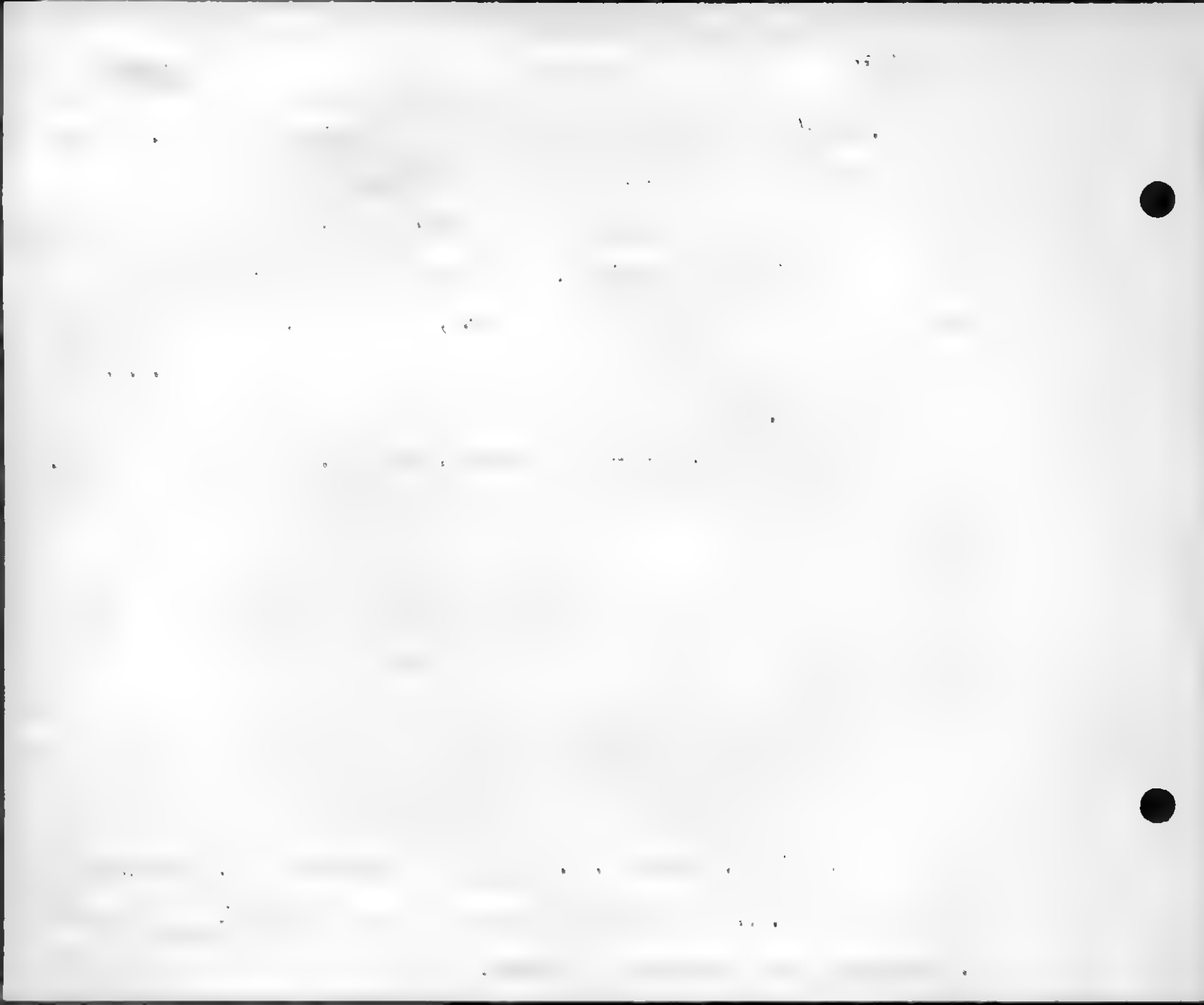
CERTIFICATE OF DEATH

16196

1 PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u>	
c. LENGTH OF STAY IN IL <u>25 years</u>		d. STREET ADDRESS <u>Rt 1 Box 218</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>Marie J.</u> Last <u>Taylor</u>		4 DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 5, 1915</u>
9 AGE (In years last birthday) <u>51</u> yrs		10 IF UNDER 1 YEAR: Months <u>6</u> Days <u>19</u> Hours <u>66</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter R. Judd</u>		14. MOTHER'S MAIDEN NAME <u>Marion Silvery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>218-28-0131</u>	
17 INFORMANT <u>Floyd F. Dean</u> Address <u>Rt. 1 Box 218 Hollywood, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Ovary.</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1, 1966</u> to <u>Nov. 6, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov. 6, 1966</u> and that death occurred at <u>7:15</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>W.H. Patrick</u>		22b. DATE SIGNED <u>11-8-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H. Patrick M.D.</u>		22d. ADDRESS <u>Lexington Park, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 8, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Waldorf, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16198

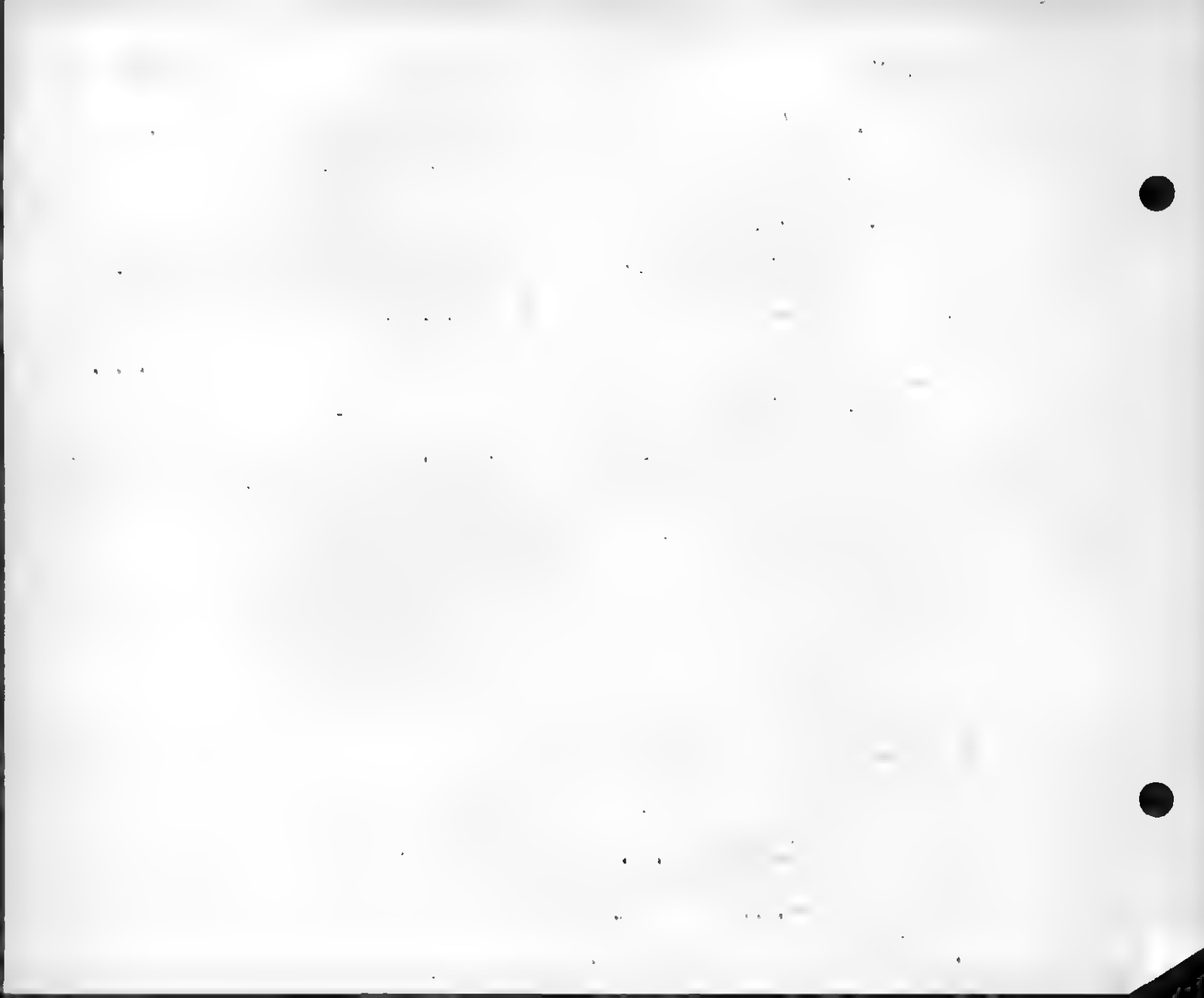
CERTIFICATE OF DEATH

16197

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtoun</u>		c. LENGTH OF STAY IN Ib <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>			d. STREET ADDRESS 										
3. NAME OF DECEASED (Type or print) <u>Helen Edna Thompson</u>			4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1966</u>										
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>May 15, 1909</u>		9. AGE (In years last birthday) <u>57</u> yrs <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min
IF UNDER 1 YEAR		IF UNDER 24 HRS											
Months	Days	Hours	Min										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>									
13. FATHER'S NAME <u>Perry Robinson</u>			14. MOTHER'S MAIDEN NAME <u>Ida Gross</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-22-0658</u>		17. INFORMANT <u>Rudolph J. Robinson</u> Address <u>Piney Point, Maryland</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> (b) <u>Polyzythemia</u> (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>29 Nov</u> , 19 <u>66</u> , to <u>30 Nov</u> , 19 <u>66</u> , that (I) (we) lost sow the deceased alive on <u>30 Nov</u> , 19 <u>66</u> , and that death occurred at _____ M, from causes on and on the date stated above.													
22a. SIGNATURE <u>Ernest M. Rehn</u>			22b. DATE SIGNED <u>2 Dec 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Ernest Rehn M. D.</u>								
22d. ADDRESS <u>Lexington Park, Maryland</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>									
23d. LOCATION (City or Town) <u>Valley Lee</u>		(County) <u>Maryland</u>		(State)									
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>			25a. REC'D BY REGISTRAR <u>DEC 3 1966</u>										
25b. REGISTRAR'S SIGNATURE <u>J. J. J. Judge</u>			25c. REGISTRAR'S NAME 										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16199

16198

1. PLACE OF DEATH a. COUNTY ST. MARY,S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY,S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMERON - RURAL		c. LENGTH OF STAY IN 1b 18.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last ALICE EDNA TROSSBACH		4. DATE OF DEATH Month Day Year NOVEMBER 7 19 66	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1901
9. AGE (In years lost birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES McKAY		14. MOTHER'S MAIDEN NAME RUTH BOHANAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-42-2807	
17. INFORMANT WILLIAM HENRY TROSSBACH - DAMERON MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Dissection 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH assumed	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WM.D. BOYD M.D.		22. DATE SIGNED 11/9/66	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county) ST. MARYS	
23a. BURIAL, CREMATION, or OTHER (Specify) BURIAL		23b. DATE THEREOF 11/10/66	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEM.		23d. LOCATION (City or Town) (County) (State) MDXX RIDGE, MARYLAND	
25a. REC'D BY REGISTRAR NOV 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

20131

0303

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16200

CERTIFICATE OF DEATH

16199

1. PLACE OF DEATH a. COUNTY ST. MARY'S LEONARDTOWN MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND COUNTY ST. MARY'S				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN 18.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS LEONARDTOWN Ms.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARY Middle FRANCIS Last YOUNG				4. DATE OF DEATH Month NOVEMBER Day 14 Year 19 66				
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-17-1911		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME COLTON YATES				14. MOTHER'S MAIDEN NAME ELEANORA NEAL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT STEPHEN R. L. YOUNG Address LEONARDTOWN				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic renal Disease (pyelonephritis). DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year 20 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.								
22a. SIGNATURE John F. Fenwick				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-16-66		
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.				22d. ADDRESS LEONARDTOWN MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-17-66		23c. NAME OF CEMETERY OR CREMATORY OUR LADY'S CEM.		23d. LOCATION (City or Town) (County) (State) ST MARY'S COUNTY MARYLAND		
24. FUNERAL DIRECTOR John M. Welch JOHN M. WELCH - LEONARDTOWN, MD.				25a. REC'D BY REGISTRAR NOV 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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